CONNECTICUT ASSOCIATION

for

ADDICTION PROFESSIONALS

"A Strong Workforce of Addiction Professionals = Best Standards of Addiction Treatment for Connecticut Residents."

Testimony: Raised Bill No. 353

Connecticut Association of Addiction Professionals' 2016 Legislative Advocacy to Address the Prescription Opioid & Heroin Epidemic

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Connecticut Association of Addiction Professionals: Proposed 2016 Legislation to Address the State's Prescription Opioid and Heroin Epidemic

Introduction

In 2015, the statistics for deaths due to overdose caused by opioids/heroin has risen to **727 Connecticut residents**. There is not one town or city in our State that has not experienced the horrific impact of the opioid and heroin epidemic. Since 2015, Connecticut opioid addicted residents are now at even greater risk due to the addition of the drug Fentanyl to street supplies of heroin. Fentanyl is significantly more potent that heroin , which it increases its desirability to addicted individuals. It has been identified as a major contributing factor in the stunning rise in deaths by overdose.

On a daily basis, the workforce of CT's credentialed addiction specialists are confronted with the daunting challenge of treating opiate addicted women and men, many between the ages of 16- 30 years old, with few treatment options. The current treatments produce outcomes less than promising.

Beginning in 2015, the Connecticut Association of Addiction Professionals conducted informal statewide survey of addiction specialists, primary care providers, licensed behavioral health providers, and consumers, respondents described a bleak picture for consumers with an opiate addiction . In Connecticut and across the nation, clients, who seek treatment, have two treatment options- medication assisted therapy or abstinence.

In multiple national research studies there is universal consensus that the origin of opioid addiction begins in the office of the primary care provider- **80% of individuals addicted to opioids/heroin report that their addiction began with a prescription of pain meds from their MDs.**

Respondents were in agreement that unfortunately, often the first point of service for the opiate addicted individual is the local ER. The consumer is rushed in by a family member or first responders due to an overdose. If fortunate, the individual is revived with NARCAN. The sad fact is that the individual is restored to exactly the same state of addiction at the time of the overdose.

Given the harsh reality and complexity of the heroin epidemic in 2016, CAAP proposes legislation, which contains prevention and treatment recommendations, as beginning steps to reduce the great suffering of CT individuals, their families, partners, and friends caused by this epidemic.

Note: The two proposed legislative policies will incur NO COST to the State of Connecticut.

Summary Statements of CAAP's Two Legislative Proposals

I. A Team Approach to the Prevention, Intervention, and Treatment of Opiate Addiction in Primary Care Settings- An Addiction Specialist and Primary Care Provider Collaboration

CAAP's first recommendation centers on preventing and intervening in opiate abuse by integrating the services of an addiction specialist into primary care practices across our State.

At a high-powered meeting of CT Senators, State Officials, consumers, and the Acting Director, Office of National Drug Control Policy, held in April 2014 at the Cornell Scott Hill Health Center, the Director of the Drug Control Policy, Michael Botticicelli shared that his addiction to prescription drugs began in his Dentist's office with a prescription for Percoset (*New Haven Independent,* April 18, 2014). There appears to be a consensus among MDs, Addiction Specialists, and opiate addicted consumers that prevention of opiate addiction needs to begin on the front line, at the office of a primary care provider

In 2014, the Connecticut Association of Addiction Professionals submitted an extensive document to the State's ***SIM initiative*-Connecticut Healthcare Innovation Plan Public Comments**. The reader may refer to CAAP's comments via the **CT Healthcare Advocate's Website.** The document included evidence of the addiction specialist's essential scope of services, which enhance the patient's medical and behavioral health treatment outcomes.

In May 2013, SAMHSA-HRSA released the report; ***Innovations in Addictions Treatment-Addiction Treatment Providers Working in Integrated Primary Care Services (SAMHSA-HRSA Center for Integrated Health Solutions).*** The report underscored the importance of this complement of services:

"The integration of primary and addiction care can help address these often interrelated physical illnesses by ensuring higher quality care."

Throughout the 2015 legislative session, several proposed bills were raised to provide basic training to MDS, APRNS, PAs, and LCSWs in specialized addiction screening methods and brief intervention strategies in substance abuse treatment. CAAP offered compelling evidence that proved that LADCs already possess the requisite training and skill sets to provide these services!

CAAP's **SIM** document contains numerous citations and references to HRSA's & SAMSHA's **major advocacy goal (June 2013)**- ***the inclusion of an addiction specialist in emerging models of integrated, multidisciplinary, and coordinated primary care medical delivery systems.***

Today, CT PCPs are challenged daily by the limitations of time and fiscal resources in providing a comprehensive evaluation of their patient's substance abuse history and current substance usage. The ICER **2014 Draft on *Treatment of Patients with Opiate Dependence* cites** numerous studies that

a "comprehensive assessment by a clinical addiction specialist to determine a patient's overall risk, presence of co-morbid disorders, including chronic pain or co-occurring substance abuse… and extent of dependence is crucial… in designing a comprehensive, individualized care plan to address the patient's needs. (ICER 2014 pp.73-74). By the inclusion of an addiction specialist, as a key provider, in primary care settings, or referral to an independent practioner, this specialist will provide the patient with a rapid diagnosis, assessment of disease progression, and develop a treatment plan based upon best practice standards for the prevention or treatment of all forms of Substance Abuse Disorders (SUD)."

CAAP strongly recommends that the General Assembly and Governor Malloy endorse a 2016 public policy initiative to prevent the onset of opiate addiction by supporting the integration of credentialed addiction specialists into primary care settings.

CT PCPs will need to develop a protocol for standard of care and referral for patients, whose opiate med prescriptions exceed medical need for their presenting condition. This referral to an addiction specialist is, as critical as, medical protocols for referrals of patients with diabetes, cardiac disease, depression, etc. Opiate addiction is a primary disease. CAAP advocates for best practice treatment of these patients throughout Connecticut's diversity of Primary Care settings. Following this protocol, the opiate abusing/dependent patients would be routinely referred to a licensed addiction specialist, who can offer comprehensive evaluation, referral, and specialized treatment. **By intervening at the time of the patient's entry into a primary care setting, the threat of opiate dependence, which may ultimately lead to overdose and/or death can be immediately addressed and effectively treated.**

II. The Implementation of Uniform, Best Practice Guidelines in the Use of Suboxone (buprenorphine) for Medication- Assisted, Office-Based Treatment by Certified Physicians in Independent Practices.

In Connecticut and across the nation, clients, who seek treatment, have two treatment options- medication assisted therapy or abstinence. Consumers are given highly addictive medications, agonist agents, Methadone or Suboxone (buprenorphine/naltraxone) that are offered at specialized clinics or thru private physicians. These medications are "replacements" transferring the dependence from a street drug to a prescribed drug with the long –term goal of abstinence. The Institute for Clinical and Economic Review's "*Management of Patients with Opioid Dependence: A Review of Clinical, Delivery System, and Policy Reports",(cepac,icer review)* May 2014 presented a cohort model of 1,000 hypothetical patients entering treatment . The model 's results of efficacy of treatment between Methadone Maintenance and Subxone & Subxone taper were remarkably similar (pp.7-10). Around 28% were drug free in two years, but each group had similar %s of relapses, **55%**-a dangerously high rate. Unfortunately, these treatments are currently **all** addiction science has to offer.

When Suboxone (buprenorphine) was introduced in the early 2000s, it was lauded as a "silver bullet" to address opioid addiction- a safe, less addictive, and short-term medication- assisted treatment with specialized counseling. Suboxone researchers described the medication as a promising alternative to long-term methadone maintenance. Fast forward to 2016, Suboxone's fidelity to its original treatment assurance has been severely tarnished. Suboxone is now a financially hot property on the street for drug trafficking, and by less than scrupulous MDs in private practice, who can boost their revenues by thousands of dollars with little external oversight. The loser is the opioid dependent client.

As respondents to the CAAP 2015 survey stated, their experiences with individuals treated with Suboxone showed a critical lack of uniform standards for treatment. As an example, clients, who participate in a Suboxone program at a not-for profit substance abuse treatment setting, hospital-based IOP, or criminal justice diversion program receive more structured and consistent monitoring of their medication. In these programs, clients are required to attend specialized recovery management groups and undergo random urine toxicology screening. Also, clients in these settings, who present with co-occurring disorders, are much more likely to gain access to additional behavioral health services thru the agency's or program's referral network- thus boosting a client's treatment outcomes.

Individuals, who choose to seek Suboxone treatment from a certified private physician are often likely to receive treatment that lacks structure, compliance oversight (ex., random UAs), and no counseling except a brief check-in session conducted by a nurse or practice assistant. CAAP respondents report that many physician- based Suboxone private practices have a caseload of **80- 100 patients** receiving the medication. These programs, due to the size of client caseloads, are

unable to diligently monitor signs of relapse, use of other drugs, and the critical psycho-social factors, which will positively or negatively impact the client's path to recovery.

CAAP found that survey respondents were unanimous in the need for conjoint specialized counseling for clients being treated with Suboxone. It is important to note that when Suboxone was introduced, the protocol advocated 6- 18 months of treatment with a target of successful tapering of doses till the client gained abstinence. Currently in Connecticut, Suboxone therapy now mirrors methadone-maintenance. Clients average 4 years of treatment on Suboxone with treatment interruptions due to non-compliance, illegal activity, etc. The message for the possibility of a drug-free life seems to be minimized. CAAP supports the position posted an article in *Addiction Treatment Magazine:*

" Studies have shown individuals who are being treated with prescription Suboxone and also take part in counseling have a much better outcome than those who continue on Suboxone alone. Counseling would prove more effective at helping the individual begin to make changes in their behavior and lifestyle so that he or she can focus on long-term recovery goals.. The counseling occurs in tandem with Suboxone treatment makes the process easier and more effective." (Nov. 2011).

In a 2013 study on the lack of essential specialized psychotherapy services for individuals engaged in MAT, Robert Lubran, director of Pharmacologic Therapies at the Substance Abuse and Mental Health Services Administration (SAMHSA), was quoted as saying:

"**The array of state legislation reflects concerns that some for-profit clinics, which distribute the synthetic narcotic to help patients beat addictions to heroin and other opiates, don't provide enough services. We know for-profit providers often provide a lower level of service" than nonprofit counterparts. Additionally there have been reports that the "group therapy" provided in some clinics is inconsistent in terms of frequency and may not be appropriately balanced between psychoeducational and psychotherapeutic services.**

The evidence is conclusive, as presented in many studies beginning in 2010 to the present, effective buprenorphine treatment should include a psycotherapeutic component in the induction, stabilization phases, and maintenance phase till taporing off the meds.

As one CAAP Board member stated: "Clients who are on Suboxone with no specialized counseling, are missing an essential process for their recovery. The treatment is inferior. It is like asking an individual with a broken leg to use only one crutch for his or her rehabilitation"!

III. Supportive Evidence for 2016 Public Policy Initiatives to Meet the Challenge of Prescription Opioid Addiction and Heroin Addiction

Introduction:
The Connecticut Association of Addiction Professionals represents over 850 credentialed addiction specialists. It is the State Affiliate for the National Association of Alcohol and Drug Abuse Counselors. The Association is served by an all-volunteer Board of Directors, who advocate for public policy that empowers the State's workforce of addiction specialists, and most importantly, the substance abusing consumers whom the workforce serves**. The licensed addiction specialist, LADC, is the statutorily recognized professional provider of addiction services in Connecticut, who has met credentialing requirements, which encompass best practice standards of care in the treatment of addictions.**

In the 2015 Spring Edition of NAADAC's publication, "Advances in Addiction and Recovery", Connecticut 's license, LADC, was nationally recognized as one of the five state licenses that established the national standard and precedent in meeting the fundamentals of excellence in the licensure of addiction specialists.

An Example of an Intervention: How the Addiction Specialist/LADC, as a member of a primary care interdisciplinary team, meets the challenge of CT's prescription opiate and heroin epidemic

Connecticut's prescription opiate and heroin epidemic is ravaging cities and towns with overdoses and deaths. The state's heroin-related deaths have shot up from 174 in 2012 to to **727** in 2015. Meanwhile, the use of heroin doubled nationally from 2007 to 2012. It would be presumptuous to infer that addiction specialists alone can solve this multi-faceted health crisis.

Research has clearly shown that for many active opioid addicts the first step to heroin addiction began with a visit to their doctor/MD for **pain management**.

As an intervention for the pain, many well-intentioned MDs routinely prescribe a prescription for an opiate with the unintended consequences of initiating a deadly relationship between the prescription pill and the vulnerable patient.

The specialized services of a licensed alcohol and drug counselor (LADC) can offer valuable interventions, like **specialized counseling** and **compliance oversight** to enhance treatment outcomes of medication assisted therapies to meet the challenge of prescription opiate and heroin abuse/addictions in patients encountered and treated by

CT pediatricians, school –based clinics, internal medicine MDs, community health centers, and hospital clinics.

The LADC/addiction specialist, as a key provider in these settings, will utilize his or her skill sets to conduct rapid diagnosis, assessment of disease progression, and develop a treatment plan based upon best practice standards for opiate addiction. The recommended treatment plan will be conveyed to the referring medical provider to ensure continuity of both medical and behavioral health care. By intervening at the time of the patient's entry into the primary care setting, the threat of opioid dependence, overdose and/or death can be immediately addressed.

The Licensed Alcohol & Drug Counselor's Contribution to CT's New Advanced Medical Home Model of Primary Care- Enhanced Medical and Behavioral Health Patient Outcomes

The Connecticut Association of Addiction Professionals submitted an extensive document to the State's ***SIM initiative (*Connecticut Healthcare Innovation Plan Public Comments)**. The reader may refer to CAAP's comments via the CT Healthcare Advocate's website http://www.ct.gov/oha/site/default.asp. The document included evidence of the addiction specialist's essential scope of services which will enhance the patient's medical and behavioral health treatment outcomes.

HRSA (Health Resources and Services Administration) & SAMHSA have made the inclusion of the addiction specialist in emerging models of integrated, multidisciplinary, and coordinated primary medical delivery systems a major advocacy goal.

In May 2013, SAMHSA-HRSA released the report; ***Innovations in Addictions Treatment-Addiction Treatment Providers Working in Integrated Primary Care Services (SAMHSA-HRSA Center for Integrated Health Solutions).*** The report underscored the importance of this complement of services:

"**Alcohol and drug addiction cost American society $193 billion annually, according to a 2011 White House Office of Drug Control Policy report. In addition to the crime, violence, and loss of productivity associated with drug use, individuals living with a substance abuse disorder often have one or more physical health problems such as lung disease, hepatitis, HIV/AIDS, cardiovascular disease, cancer and mental disorders such as depression, anxiety, bipolar disorder, and schizophrenia…**

The integration of primary and addiction care can help address these often interrelated physical illnesses by ensuring higher quality care. In fact, clinical trials have demonstrated that when someone has a substance abuse problem and one or more non related disorders, integrated care can be more effective than traditional treatment delivery (i.e., separate, siloed primary care and substance abuse programs) in terms of clinical outcome and cost. It results in better health

outcomes for individuals, in contrast to back-and-forth referrals between behavioral health and primary care offices that result in up to 80% of individuals not receiving care… (SAMSHA- HRSA, May 2013 Report)

Addictions--- Second Tier Behavioral Health Disorder

There still remains an insidious and subtle barrier that CT residents, and their significant others, encounter in accessing care in both in-patient and out-patient healthcare settings. It is the frankly dangerous and unfair perception that addiction is a second tier disorder. **Addiction is a Primary Disease!**

In Connecticut and many other states, the denial of prompt and critical SA treatment, based upon a blaming and the negative model of care that directs the access to services on a protocol of failure**,** continue to strengthen the barriers of shame and stigma related to SUD.

Through multiple reporting venues beginning in 2012, the state has identified adolescents and young adults as a key consumer group who are in greatest need of less problematic access to SA treatment. As an example of the synergy between shame and barriers to treatment, it is not unusual for youth and young adults to be denied inpatient treatment until these consumers have "failed " at out-patient and intensive outpatient treatment.

With this sector of the population presenting with ~~the~~ soaring rates of opioid addiction and overdoses leading to death, this model is an egregious and barbaric system of care. Dr. Sharon Levy in her presentation at the 2014 Harvard Medical School's Symposium on Addictions (March 1.2014) cited the following evidence of the prescription to heroin epidemic.
"In adolescents, recreational use of prescription painkillers accounted for 17.1% of all illicit drug use initiations beginning in 2009- more than any other drug than marijuana. Dr. Levy further cited that 1 out of 8 high school seniors reported using a prescription opioid for recreational/ non-medical use.

In contrast, Connecticut's health care treatment standards do not block or withhold necessary medical intervention and treatment from youth and young adults who have diabetes by withholding insulin medication until the young patient has a diabetic induced shock, as it does with its current stigmatizing standard of "failure of SA treatment level" to gain a therapeutically appropriate level of care.

It is important to note that the **ACA (**Affordable Care Act) **cites credentialed addiction specialists as required members of the ACA's Workforce-*Mental Health Professionals.* With the State's implementation of the advanced medical home, the credentialed addiction professional's highly specialized skills and expertise in**

providing evidence-based SA Treatment will be vitally important to ensure residents' successful health/behavioral health outcomes.

If the State chooses not to give full parity to licensed addiction specialists in its behavioral health provider, public and private payer network, the greatest risk will be to CT residents. Consumers, who seek substance abuse treatment, will be in jeopardy of loosing access to evidence-based treatment and the highest standards of care for their addictions by the statutorily identified behavioral health provider - the Licensed Alcohol & Drug Counselor (LADC). **This point is particularly relevant, as it applies to the extremely complex and unfortunately limited treatment options for opioid addiction.**

CT has a moral obligation to provide its residents, families, and partners impacted by the disease of addiction, with insurance coverage that promotes swift access to evidence-based levels of care, qualified specialists, and fiscal coverage and reimbursement policies which are equal to the complexities inherent to the disease. Let us always remember that addiction is a treatable disorder, but if not treated with appropriate standards of practice, addiction **is a terminal illness.**

Current Barriers to Best Practice SA Treatment
Parity of Substance Abuse Treatment Services
and
Public and Private Reimbursement
for
Provider Fees

Addiction professionals and consumers from across CT regularly report to CAAP Board Members that insurance carriers' current practices create severe barriers to SA treatment. <u>The barriers are all about money in the form of savings to Private Insurance Carriers in an array of fiscal defense strategies!</u> These strategies include:

- Rationed utilization methods for course of treatment and length of stay to inpatient and outpatient treatment
- Questionable protocols for denial of claims.
- Network of providers, who may not possess the credentialing standards of educational and professional experience in the treatment of SUD.
- Low rates of reimbursement with no increases to providers in several years.
- The 2015 Connecticut Budget proposal that attempted to eliminate Medicaid reimbursements to licensed behavioral health providers!
- Flawed access to SA treatment. Examples include; **many Medicaid patients who often present with the most complex medical and behavioral health disorders receive marginal treatment or encounter serious systemic barriers to care- lengthy waiting periods for healthcare appointments; language**

issues; complicated and uncoordinated referral processes to specialists; patient stigmatization due to life-style and misinformation about the disease of Addiction.

- <u>The current issue that impacts residents with private insurance in Connecticut-</u> **Across the state, a significant number of private practioners, psychiatrists, APRNS, Masters level licensed behavioral health providers are opting out of accepting private insurance but operating their independent practices on a fee for service system. This shift in payer reimbursement has created the Perfect Storm that wages havoc on residents, families, and partners, who seek SA treatment in Connecticut's fractured Access to Care system.**

If the state of Connecticut is serious and determined to address the growing numbers of its residents' addiction to prescription opioid and heroin, it is time to pass enlightened and robust public policy that saves lives and supports recovery.